

INCOME CONTINUATION INSURANCE CLAIM INSTRUCTIONS

Complete the Claim Form by printing and using a black pen. Personally identifiable information and medical information will not be used for any purpose other than for the administration of the benefit programs administered by the Department of Employee Trust Funds (ETF).

Steps in Filing

1. Employer provides an Income Continuation Insurance (ICI) booklet, Claim Form (ET-5352) and Medical Report form (ET-5350) to employee.
2. Employee completes and signs the Claim Form.
3. Employee sends the Claim Form and a copy of the current position/job description to ETF, PO BOX 7931, MADISON WI 53707-7931.
4. Employee completes and signs the front page of the Medical Report form.
5. Employee gives the Medical Report form to the attending physician. The physician is to complete the back page of the Medical Report form and send it directly to ETF.
6. When ETF receives the Claim Form from the claimant, the Claim Form is imaged into workflow and the administrator processes the electronic claim. The claims administrator sends the Employer an ICI Employer Statement form (ET-5351). The employer must complete and return the Employer Statement to ETF. ETF will electronically transmit the Employer Statement to the claims administrator. The Claim Form, Medical Report form and Employer Statement must all be received before any benefits are payable.

Employee Instructions

1. Complete every question on the Claim Form to avoid a delay in benefit payments.
2. The "Last Day Worked" is the last date you were physically at work.
3. The "First Date Disabled" is the first date you believe you were incapable of working.
4. The "Date First Treated" is the first date you saw a physician on or after your last day worked.
5. List all physicians, hospitals, clinics, therapists and other health care providers that have been involved in the treatment of your disabling condition since your last day worked (attach additional sheets of paper if necessary).
6. Return the completed Claim Form to ETF within one month after disability begins, or as soon thereafter as reasonably possible. A claim will be denied if received more than 12 months after the disability begin date, as determined by the claims administrator, Aetna. Benefits cannot be paid for the period more than 90 days prior to the date ETF receives the completed Claim Form.

Note: It is extremely important for you to immediately receive treatment from a physician. "PHYSICIAN" means a medical doctor, doctor of osteopath or surgeon licensed to practice by a state within the United States of America. A licensed PHYSICIAN does not include the CLAIMANT. A PHYSICIAN also includes such other licensed medical professional (for example, a podiatrist, dentist, nurse practitioner, physician's assistant, psychologist) who is acting within the lawful scope of his/her license and performs a service which is supervised by a licensed medical doctor, a doctor of osteopath or surgeon (not required for D.P.M. or D.D.S.). Normally, the first day of the elimination period will be the day after the last day worked. The first date of treatment by a physician after your last day worked is the first possible day the elimination period can begin.

Mail to: ETF, PO BOX 7931, MADISON WI 53707-7931



Department of Employee Trust Funds
INCOME CONTINUATION INSURANCE CLAIM FORM
 Wis. Stat. § 40.61 and 40.62

SEE BACK FOR INSTRUCTIONS—PRINT IN BLACK INK

Name (Last, First, Middle, Maiden)		<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security Number																									
Occupation (Title)/Classification		Employer/Agency		Birthdate (MM/DD/CCYY)																									
Division/Location																													
What is the nature of your disability? Describe complications, if any.																													
Last Day Worked		First Date Disabled		Date First Treated																									
Expected Return to Work Date																													
Name of Attending Physician		Complete Address (Street, City, State, Zip Code) & Telephone No.		Specialty																									
Dates of Care (MM/DD/CCYY)																													
Names of Other Health Care Providers Treating You		Complete Address (Street, City, State, Zip Code) & Telephone No.		Specialty																									
Dates of Care (MM/DD/CCYY)																													
<p>Have you applied for any of the following benefits or do you have other employment? An applicant for ICI benefits must take all necessary action to obtain and assign any other benefits available. Notify ICI if any other benefits/source of income become payable.</p> <table style="width: 100%;"> <tr> <td style="width: 15%;">Yes</td> <td style="width: 15%;">No</td> <td style="width: 35%;"></td> <td style="width: 15%;">Yes</td> <td style="width: 15%;">No</td> <td style="width: 35%;"></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Wisconsin Retirement System</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Social Security Administration</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>LTDI</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Unemployment Compensation</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Worker's Compensation</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other Plan or Other Employment (specify)</td> </tr> </table>						Yes	No		Yes	No		<input type="checkbox"/>	<input type="checkbox"/>	Wisconsin Retirement System	<input type="checkbox"/>	<input type="checkbox"/>	Social Security Administration	<input type="checkbox"/>	<input type="checkbox"/>	LTDI	<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Compensation	<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	Other Plan or Other Employment (specify)
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<p>I understand that Wis. Stat. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims, and hereby certify that, to the best of my knowledge and belief, the above information is true and correct. I hereby authorize any and all physicians, hospitals, clinics, State and Federal Agencies, the Social Security Administration, etc., to release to the Income Continuation Insurance Program third party administrator Aetna and/or the Department of Employee Trust Funds information from my health, rehabilitation, employment, Worker's Compensation, Unemployment Compensation or Social Security records. I understand the specific type of information to be released includes any and all medical and/or treatment records, and may include records pertaining to alcohol abuse, drug abuse, records with reference to child abuse, developmental disabilities, mental illness, HTLV-III (AIDS) testing and results, and/or treatment records. This release is being made for the purpose of determining eligibility for disability benefits. A copy of this authorization shall be considered as effective and valid as the original and shall be valid for the duration of the claim, but not to exceed one year from the date signed.</p>																													
Signature of Claimant			Date Signed (MM/DD/CCYY)		Telephone Number ()																								
Claimant's Address (Street, P. O. Box, City, State and Zip Code)																													

ADMIN. USE	Employer Number	<input type="checkbox"/> Prior Claim <input type="checkbox"/> Cov. via EOI—Approval Date _____	
	Name Then (if different)	_____	
	Normal Retirement Age	_____ Protective Category NRA _____	
	Biweekly Benefit Amt.	\$ _____ Monthly \$ _____	
	Date Disability Begins	_____ Benefits Begin _____	
	Taxable Percentage _____ %		

